The Surrey Park Clinic

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

The Surrey Park Clinic is operated by The Surrey Park Clinic (IHG) Ltd. Facilities include one treatment room for minor outpatient surgical procedures, a pre and post-surgical rest room, three consulting rooms and a pharmacy for outpatient dispensing. The service provides specialist female healthcare including a gynaecological clinic, hormonal clinic, minor outpatient procedures and ultrasound scans, mostly for adults.

We visited this clinic in October 2016 as part of our national programme to inspect and rate all the independent healthcare providers.

At that time, we rated the service overall as requires improvement. However, we rated well-led as inadequate because of the lack of formal governance structures and governance oversight. There was no registered manager and processes for granting and maintaining practising privileges did not have the oversight of a clinician.

There were three regulatory breaches. We told the hospital it must give us an action plan showing how it would bring services into line with the regulations. The hospital provided a plan.

At this announced follow up inspection, we focussed on the action plan and found the hospital had taken positive action to improve.

The hospital had taken action to comply with the regulations and had:

- Obtained registered manager status for an appropriate member of staff
- Formalised governance arrangements
- Implemented processes to ensure the granting and reviewing of consultant practising privileges was correct.
- Taken action to ensure staff understood and discharged the duty of candour.
- Put monthly hand hygiene audits in place and started a process to ensure flooring in the clinical areas complied with national guidance Health Building Note 00-09; Infection control in the built environment.

During our inspection we also looked at the two actions from the last report the hospital should take to improve:

- Action to measure and benchmark patient outcomes in a way that does not involve over reliance on patient satisfaction feedback.
- Ensure all clinical staff received an appropriate level of safeguarding training in line with national guidance

We found those actions had also been achieved.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Following this inspection, we told the provider that it that it should continue to make improvements, even though a regulation had not been breached, to help the service improve.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to The Surrey Park Clinic

The Surrey Park Clinic is operated by The Surrey Park Clinic (IHG) Ltd. The service opened in 2005 to provide specialist female healthcare including a gynaecological clinic, hormonal clinic, minor outpatient procedures and ultrasound scans. It is a private clinic in Guildford, Surrey. The service primarily serves the communities of Surrey and only sees patients who are privately funded. Referrals are also accepted for patients outside this area. The service is registered to provide the following regulated activities.

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder and injury.

At the comprehensive inspection in October 2016 the service did not have a registered manager in post but submitted an application immediately and at the time of this follow up inspection, the general manager had been registered with the CQC from January 2017.

Following the inspection in October 2016 the hospital was found to have breached three regulations:

- Regulation 17 HSCA (RA)Regulations 2014 Good governance
- Regulation 20 HSCA (RA) Regulations 2014 Duty of candour
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This was because:

- There had been no registered manager since the previous owner changed roles over a year before the inspection. There was no up to date statement of purpose or formal governance structure.
- Staff did not fully understand the duty of candour and did not always discharge their responsibilities under this to patients when things went wrong.
- There was no regular infection prevention and control audits or risk assessments to detect and control the spread of infections, including those that are healthcare related.

Our inspection team

The inspection was led by a CQC Inspector supported by an inspection manager. The inspection was overseen by Alan Thorne, Head of Hospital Inspection (South East).

How we carried out this inspection

We inspected one core service at the hospital which covered all the activity undertaken. This was outpatients and diagnostic imaging.

During our visit, the hospital provided us with a copy of their completed action plan from the previous inspection. In addition, they supplied comprehensive documentary evidence that evidenced the actions that had been completed. We reviewed this information in detail.

As a focused inspection, we conducted interviews with key members of the hospital senior management team, toured relevant clinic facilities and spoke informally with staff to test and corroborate the documentary evidence supplied. We observed meeting minutes, reviewed audits and checklists and reviewed four staff files.

Our interviews and observations and the documentary evidence supplied by the hospital gave us a satisfactory level of corroboration to provide assurance that the required improvements had been made.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are outpatients and diagnostic imaging services safe?

In October 2016 we rated safe as **requires improvement.**

As we only inspected those areas identified as a breach of the regulations or were of concern in October 2016, and not the safety overall, we are unable to rerate this service. However, we found that sufficient action had been taken to ensure the service met the relevant regulations, and had addressed all the concerns identified as described below.

At our October 2016 inspection the provider was told it must take action because:

- Staff did not fully understand the duty of candour and did not always discharge their responsibilities under this to patients when things went wrong. This was a breach of a regulation.
- Flooring in clinical areas did not comply with the requirements of Health Building Note 00-09; Infection control in the built environment.

In addition the provider was told it should take action to:

- Ensure all clinical staff received an appropriate level of safeguarding training in line with national guidance.

At this focussed follow up inspection we found the necessary improvements had been made.

Incidents

- Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) duty of candour was introduced in November 2014. This regulation requires the organisation to notify the relevant person an incident has occurred, provide reasonable support to the relevant person, in relation to the incident and offer an apology.
- The duty of candour policy had been updated and circulated to staff. All staff had completed training on duty of candour and staff spoken with described the training they had completed and how that would be applied in practice.
- All workstations had a note attached with a definition of duty of candour and how this was to be exercised. This information acted as reminder to all staff.
- Duty of candour had been discussed at both governance and team meetings and this was confirmed by the meeting minutes. The manager spoke of a more open and transparent approach in all discussions about any incidents and staff spoken to confirmed this.
- The senior nurse at the clinic had completed root cause analysis training. We looked at a recent root cause analysis of an incident and found this was completed correctly with appropriate analysis and recommendations that were actioned. In this instance, we saw duty of candour was exercised.

Infection prevention and control

- Hand hygiene audits were taking place. Results in May 2017 showed staff failed to achieve full compliance in four areas with only 50% of clinical staff being bare below the elbows. There was an action plan in place highlighting areas of non-compliance and a plan to re audit in July 2017 to ensure actions were taken. On the day of inspection all clinical staff were bare below the elbows.
- At our October 2016 inspection the hospital was told it must take action as the clinic had carpets throughout with the exception of the treatment room, bathrooms and sluice. There were fabric curtains and upholstered chairs in the consulting rooms which were difficult to

keep clean. The Department of Health Building Note (HBN) 00-09: infection control in the built environment states "Spillage can occur in all clinical areas, corridors and entrances".

- At this focussed inspection we saw one additional clinical area, room five, had its carpet replaced with appropriate flooring which was wipeable and easy to keep clean and complied with Health Building Note 00-09: infection control in the built environment. There was a plan to replace carpets in all clinical areas and we saw email evidence that this plan was being discussed. There was no clear date for completion of this plan.
- We saw that remaining carpets were visibly clean and free from stains. Clinical rooms had fabric curtains and upholstered furniture but we saw there was a plan to remove these from room five. A risk assessment had been completed for carpets in clinical areas and soft furnishing on chairs; this showed that control measures were in place.
- Staff were able to tell us what would be done if carpets or fabrics were soiled and the frequency of cleaning that was carried out daily with deep cleaning done on a six monthly basis.
- A national cleaning standards audit was completed monthly; the most recent results for May 2017 showed remedial actions had been taken to address some areas of non-compliance.

Safeguarding

- Records showed all registered nurses and sonographers (specialised healthcare workers trained to do diagnostic ultrasound), were trained to a minimum of level two for safeguarding vulnerable adults and children. Certificates showing completion of training were kept in staff personnel files.
- The senior nurse was trained to level three and was designated as safeguarding lead.
- Arrangements had been made for healthcare assistants to complete level two training at the local trust hospital to be completed by December 2017.
- The hospital safeguarding policy had been recently reviewed and included the requirement for training in line with national guidance. There was a process flowchart showing actions staff should take if they suspected abuse this showed the contact details for the local safeguarding board.
- A female genital mutilation (FGM) policy was in place which given the nature of the procedures carried out at the clinic recognised that all staff needed to understand and know how to record and report any findings of FGM.

Are outpatients and diagnostic imaging services effective?

We do not rate effective for outpatient and diagnostic imaging in sevices we inspect.

In October 2016 we inspected effective and told the service it should take action in this area because:

- The service used patient satisfaction audits to measure outcomes. Patient satisfaction results can be very subjective and may not always provide a robust tool for measuring outcomes.
- Consultant files showed gaps in the documentation required to support practising privileges at the service, which meant the clinic might not have had assurances all medical staff at the clinic were competent and fit to carry out their role.

At this focussed inspection we found the following.

Patient outcomes

- The clinical governance meeting showed patient outcomes were discussed and monitored. The clinic collated the results of patient satisfaction surveys. The clinic was auditing labiaplasty outcomes monthly and now collected data on the number of readmissions and repeat procedures. We saw the results of these and noted there were no immediate concerns.
- The governance committee discussed how the clinic could benchmark practice externally and advice had been sought from another external specialised clinic how this might be achieved. Given the specialised work of Surrey Park Clinic the service continued to look for ways to benchmark practice.

Outpatients and diagnostic imaging

- The audit programme had been reviewed to include care pathway completion and the most recent audit showed 19 notes checked with an attached action plan to ensure pathway documentation was fully complete.

Competent staff

- All consultant personnel files had been subject to audit to ensure all information held on file relevant to practising privileges was current. We checked four files and found a new checklist had been developed and was at the front of the file showing relevant checks completed and any outstanding information required. A process had been established to collect the relevant information and we found there was a clear escalation process if information was not submitted.
- Consultant files were in the process of being reviewed by the Medical Advisory Committee (MAC) Chairman who reviewed appraisals and any other clinical relevant information. We saw feedback was given to the clinic manager about any information still required and any actions to be taken.

Are outpatients and diagnostic imaging services caring?

We did not inspect this area of the service, as this was a focussed follow up inspection.

Are outpatients and diagnostic imaging services responsive?

We did not inspect this area of the service, as this was a focussed follow up inspection

Are outpatients and diagnostic imaging services well-led?

As we only inspected those areas identified as a breach of the regulations or were of concern in October 2016, and not the well-led overall, we are unable to rerate this service. However, we found that sufficient action had been taken, and significant progress had been made in in establishing a governance structure and robust support processes. This meant the relevant regulations were now being complied with and other concerns adressed.

At our October 2016 inspection we rated well led as **inadequate**. The service was told it must take action because:

- There had been no registered manager since the previous owner changed roles over a year before the inspection. This was a breach of a regulation.
- There was no up to date statement of purpose for the service or a specific set of values. Information that was available referred to the previous owner and registered manager who had left the role over a year ago.
- There was no formal clinical governance structure and no minuted meetings to review governance.
- There was no Medical Advisory Committee to oversee clinical practice and ensure clinical care met the highest standards of safety and quality.
- Practising privileges were granted and reviewed by staff that were not clinical.
- There was no formal risk register to identify and monitor risks.
- These governance issues were a breach of regulation.

At this focussed inspection we found:

Leadership and culture of service

- The general manger was registered with the CQC from January 2017. In addition the manager had completed Skills for Care – Well Led training. Details of the registered manager were displayed in the main reception area.
- The statement of purpose was reviewed and submitted to CQC in February 2017 and was appropriate for the service.

Governance, risk management and quality measurement

- The service had established a Medical Advisory Committee (MAC) to meet every three months. Minutes of the first meeting, dated March 2017, showed discussion of adverse events, complaints, patient feedback, practising privileges, infection prevention and control, business development, policy and audit review.
- The MAC was chaired by the newly appointed medical advisor (called specialist advisor). The medical advisor was an experienced medical clinician and we found

there was evidence of due diligence in their appointment process. A role profile showed this role would advise on doctor's applications for practising privileges at the clinic.

- Governance committee minutes demonstrated monthly meetings. Standing agenda items included incident reports, complaints, infection prevention and control, business development, policy and audit review. Minutes showed changes to procedures and policies as a result of learning from incidents.
- An annual governance report for 2016 was completed. This showed analysis of complaints and incidents and appropriate responses. There was also a report of some outcome data.
- We found staff meetings were held and minuted at least every two months. Minutes showed links to topics in the governance report demonstrating information was shared with staff. Copies of minutes were sent to staff that were not able to attend.
- Following the inspection in October 2016 the service had developed a project plan which listed improvements to be made. Accountabilities were noted but time scales were required to ensure actions occurred in a timely way.
- The Health and Safety Risk Assessment Register showed actions to be taken in the case of an interruption to normal services. There were no other current risks noted that might need to be considered.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all that all governance arrangements continue as established and all actions on the improvement plan should have timings to ensure those responsible are accountable for timely completion.
- The provider should ensure the plan to replace all flooring in clinical areas continues.
- The provider should ensure all clinical staff including healthcare assistants receive an appropriate level of safeguarding training in line with national intercollegiate guidance.